Case Report

Ganser syndrome in adolescent male: A rare case report

Supriya Agarwal, Abhinav Dhami, Malvika Dahuja, Sandeep Choudhary

Address for correspondence: Supriya Agarwal, Dept. of Psychiatry, Chhatrapati Shivaji Subharti Hospital, Netaji Subhash Chandra Bose Subharti Medical College, Swami Vivekanand Subharti University, Meerut, U.P., India. Email-drsupriya.agar@gmail.com

Abstract

Ganser syndrome, a rare variation of dissociative disorder, is characterised by approximate answers to real questions, dulling of consciousness, hysterical neurological changes and pseudo-hallucinations. First described by the psychiatrist-Sigbert Ganser in 1898 in prison inmates, it has acquired the synonym 'prison psychosis'; rarely, it has been described in normal population in various age groups. Since its description, this syndrome has been a controversial diagnosis with uncertain management strategies. In this paper we discuss the presentation and management of Ganser syndrome in an Indian adolescent male.

Key words- Adolescence, Ganser Syndrome, Dissociative Disorder

Introduction

Ganser syndrome is a rare variation of dissociative disorder named after Sigbert Josef Maria Ganser, who characterized it in 1898 as a hysterical twilight state. Cocoress et al [1] and Giannini & Black [2] wrote about this disorder in literature way back in late 1970s and 1980s. According to Andersen et al [3], it is also known by multiple other names like Balderash Syndrome, Prison psychosis etc. According to Giannini & Black [2], individuals of all backgrounds have been reported with the disorder, but the average age of those with Ganser Syndrome is 32 years. Miller et al [4] state that the disorder is apparently most
common in men and prisoners, although prevalence data and familial patterns are not established and still remain controversial, and it is rarely common in children. Giannini & Black [2] have quoted the symptom of “passing over (vorbeigehen)”— the correct answer for a related, but incorrect one is the hallmark of Ganser Syndrome. And, the neurological examination may also reveal signs of “hysterical stigmata”—a non neurological analgesia or shifting hyperalgesia. To our knowledge, this syndrome has rarely been reported in adolescence and also very few cases of this syndrome have been published of patients who are not prisoners. Moreover, due to uncertainty and controversies pertaining to not only the diagnosis of the disorder but also regarding its management in clinical set up, it is imminent to discuss Ganser syndrome. Thus, in this paper we propose firstly, to discuss clinical presentation of the Ganser syndrome in an adolescent boy; and secondly, to discuss other differential diagnosis in similar cases and also to review the strategies to be considered for its management.

Case Description

A 15 year adolescent boy, studying in 10th class presented with acute onset of disorientation to time, place and person, irrelevant talks and abnormal behaviour since 4-5 days. On evaluation, history of being bullied for few months was revealed by his distraught parents. According to them, bullying had been going on for few months. However, the distress in patient had clear temporal relationship with being reprimanded in school by class teacher following an altercation with the bullies. Following this, patient refused to go to school and abruptly started forgetting his personal details like his name and address and also refused to recognize his family members. He became aggressive and abusive towards his family members and would often ask where he was and what was he doing in stranger’s house; at times even failing to recognize his own house. He would wake up at night and start taking his clothes off saying that he is feeling suffocated. According to his family, this behaviour was
very unlike the patient’s usual behaviour. On Mental Status Examination, the patient at times was disoriented. His mood according to him was euthymic, but he appeared perplexed and had a labile affect. He would answer incorrectly to many of the questions and would give approximate answers (vorbeireden) e.g. when he was asked as to when was he admitted in hospital, he would answer “2 years back”, although he was in hospital for one week. On asking what number do we get if we add 3+3, the patient answered “4”. Pseudo-hallucinations and confabulation were also documented in the patient. His personal and developmental history was unremarkable. No concerning personality issues were found. Family was very supportive with no interpersonal conflicts within the family. Patient was social, had a few friends in school and neighbourhood. Used to go out to play cricket with friends after school hours and maintained cordial relations with them. No past history or family history of any conduct disorder, truancy, delinquency, substance use, high risk behaviour, any major physical, neurological or mental illness or sub-normality, or legal complications, homicide, suicide or self harming behaviour was present. Physical examination was unremarkable. Routine blood investigations and computerized tomography of head were within normal limits.

At first following differentials including- Acute and transient psychotic disorder, Factitious syndrome, Ganser syndrome and Malingering were kept in mind. During the hospital stay and continued serial mental state examinations, a diagnosis of F 44.80 Ganser Syndrome as per International Classification of Diseases- 10th Edition (ICD-10) criteria was established. Initially, the patient was started on Olanzapine 2.5 mg which was later increased to 5 mg. Following a session of abreaction using inj. lorazepam 4mg on the 3rd day of admission, patient showed significant improvement in orientation and dissociative symptoms. Following this, the patient’s condition started improving gradually over a period of 1 week. Patient’s family was psychoeducated about the nature and course of illness and possible role of stressor
in precipitation of this disorder. Also, the need for continued follow up visits and enhancement of coping in patient was also stressed upon during psychotherapeutic sessions. Patient completely improved on 7th day of treatment and was discharged on the same regime. Patient resumed his studies in a different school and started following his pre-morbid daily routine. He remained compliant to medication which was gradually tapered off over 3 months period. As the patient responded within a week and as there are no definite duration guidelines for the treatment of Ganser syndrome with antipsychotics; Olanzapine was tapered off after 3 months.

**Discussion**

According to Drob and Meehan [5], Ganser Syndrome is briefly described as ‘other dissociative (conversion) disorders’ (F44.80) in ICD-10, and is a poorly understood and often over looked clinical phenomenon. As stated by Daniel et al [6], the aetiology of Ganser syndrome is still not clear; ranging from malingering to dissociation to schizophrenia to organic brain lesions, head injuries, seizures etc., as reported in various case reports across the world since last many decades.

To the best of our knowledge, this is a rare case of Ganser Syndrome, as it is not very common especially in this particular age group. This case showed three of the four major diagnostic features of the Ganser Syndrome, i.e. giving approximate answers, clouding of consciousness with total duration of illness being two weeks. The patient was fulfilling the criteria of Ganser Syndrome as per ICD-10, so a diagnosis of Ganser Syndrome was made.

As mentioned by Ruddy & House [7], there are no definite guidelines regarding the treatment of Ganser syndrome and many case reports mentioned the use of low dose antipsychotics in the treatment of this condition, we used Olanzapine as antipsychotic and abreaction combined in this patient. Many of the reported cases are of adult age groups. Michel Spondenkiewicz et al [8] reported a case of Ganser Syndrome in a 14 year old girl who presented with insomnia,
logorrhea (increased thought productivity), anxiety with incoherent discourse and amnesia of recent events, such as her aunt’s death and a recent holiday. In adults, Grieger and Clayton [9] described the case of a 25-year-old woman with a history of recurrent depression who presented with Major Depressive Disorder a few weeks after resolution of Ganser Syndrome. Haddad [10] reported a similar case of a 31-year-old man with a mild mental handicap who presented Ganser Syndrome which resolved after one week which was immediately followed by Major Depressive Episode. Apter et al [11] have postulated that for a large number of patients that the development of severe regression and dissolution of the Ganser Syndrome is facilitated by the presence of serious co morbidity, such as Affective Disorders. Haddad [10] states that the Ganser syndrome and depression are also considered as separate manifestations of a common underlying conflict. When it is no longer defence, guilt and symptoms of depression appear.

Even though the Ganser Syndrome is uncommon in children and adolescents, its recognition is necessary to distinguish this disorder from psychotic disorders, especially in adolescence. Our case supports the view that children and adolescents with Ganser Syndrome should be admitted for assessment and suggests the need for follow up after apparent recovery. The family should be psychoeducated regarding the illness. Psychotherapy to explore the inner conflicts is also important in such cases and abreaction still could be considered as treatment option for rapid dissolution of symptoms. Myth that Ganser Syndrome occurs only in prisoners should be challenged by the vigilant clinicians.

**Conclusion**

Diagnosis of Ganser Syndrome should be considered in patient of any age group presenting with altered sensorium, disorientation, vorbeireden, pseudo-hallucinations and/or confabulation. Multiple differential diagnoses including acute and transient psychotic disorder, factitious disorder and malingering should be discussed. Treatment strategies like
anxiolytics, antipsychotics and abreaction therapies can be used alone or in combination for management.

**Conflict of interest**-none

**References**


Supriya Agarwal, Associate Professor; Abhinav Dhami, Junior Resident; Malvika Dahuja, Junior Resident; Sandeep Choudhary, Professor and Head. Dept. of Psychiatry, Chhatrapati Shivaji Subharti Hospital, Netaji Subhash Chandra Bose Subharti Medical College, Swami Vivekanand Subharti University, Meerut, U.P., India.